Hearing Aid Information Form

Name: _____

Hearing Aid Information:

Brand: _____

Model: _____

Serial Number (Left): _____

Serial Number (Right): _____

Batteries: _____

Ear Piece Information

Earpiece Type: _____

Serial Number (Left): _____

Serial Number (Right): _____

Clinic Information

Clinic Name: _____

Provider Name: _____

Clinic Phone Number: _____

Clinic Address: _____

Warranties

In-Clinic Service Warranty Expiration Date: _____

Manufacturer Repair Warranty Expiration Date: _____

Loss Warranty Expiration Date: _____

Loss Warranty Deductible: _____

Clinic Service Costs (After In-Clinic Service Warranty)

Cost to clean hearing aids: _____

Cost to reprogram hearing aids: _____

Cost to repair hearing aids (out of warranty): _____